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The American Journal of Public Health

ISSN 3064-6677

Research Article

The Role Of Utilizing Community Oncology Care To Decrease Cancer-Related Financial Toxicity.

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PURPOSE

The cost of cancer care in the United States remains a significant concern, particularly considering the rising expenditures associated with oncology services[1]. Cancer related financial toxicity - the economic burden of cancer care to patients and their families - has increasingly become a critical factor when evaluating quality-of-care. A notable area of distinction between community oncology practices and hospital-based oncology practices arises not from pathway, but from cost. Community oncology practices represent a valuable resource to mitigate financial toxicity by providing affordable, clinically equivalent care at significantly less cost. This review explores the factors contributing to cost differences, supported by scientific literature and empirical evidence.

METHODS

This integrative literature review aggregates peer-reviewed medical, pharmaceutical, and economic articles, and white papers from the last ten years. Scholarly database searches focused on "financial toxicity," "340B drug pricing," "cancer care spending," "facility fees in oncology," and "site neutral payments". A historical review of associated healthcare policy impacts, health benefits and claims data are also included. Forty-three publications were reviewed. Fourteen publications were excluded for publication prior to 2014, acknowledged flaws, or acknowledged measurement bias. Limitations and bias were addressed through the utilization of multiple reviewers and focused data screening. Data from comparative studies is compared by site of care to assess trends in cost differences.

KEY TAKEAWAYS

- Community oncology practices consistently deliver high-quality cancer care at significantly lower costs than hospital-based settings.
- Major cost drivers include drug pricing, facility fees, and markups, all of which are lower in community settings.
- Policy reforms such as site-neutral payments could save billions and reduce patient financial toxicity.

ANALYSIS

Community oncology practices provide outpatient cancer care independent of hospital or academic affiliation. In contrast, hospital-based practices are often affiliated with larger healthcare systems, may provide inpatient and outpatient services, and often provide care for more complex patients. The structural and operational differences between these settings, including the cost of chemotherapy, issues arising from complexity of care, facility fees, discounted treatment pricing arrangements, markups, lack of price transparency, and the impact of regulatory policies such as the 340B Drug Pricing Program contribute to variations in cost.

Current estimates of the annual cost of cancer care in the United States are expected to reach $246 billion in 2030[2] from $183 billion in 2015[3]. A study on cost across different cancer types, geographies, patient ages and number of chemotherapy sessions found the mean total cost per month was significantly lower in patients treated in a community-based practice ($12,548) compared to a hospital owned practice ($16,555)[4].This lower cost was sustained whether the chemotherapy was branded ($6,674 community oncology d vs $10,900 hospital owned), generic ($2,936 community

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Received: 09-Oct-2025, Manuscript No. TAJOPH-5171 **; Editor Assigned:** 10-Oct-2025 **; Reviewed:** 29-Oct-2025, QC No. TAJOPH-5171 **; Published:** 06-Nov-2025, **DOI:** 10.52338/tajoph.2025.5171
Citation: **Lucio Gordan**. The Role Of Utilizing Community Oncology Care To Decrease Cancer-Related Financial Toxicity. The American Journal of Public Health. 2025 November; 14(1). doi: 10.52338/tajoph.2025.5171.
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oncology vs $5,134 hospital owned), or combined branded plus generic ($11,080 community oncology vs $19,412 hospital owned).[3]

A pharmaceutical analysis ranked the anticancer drug class first, in terms of global spending, in the pharmaceutical market at $91 billion in 2013 up from $71 billion in 2008[5]. A 2012 analysis of United Healthcare claims data analyzed found a range of costs for early-stage breast cancer patients ranged from $9,000-$22,000 for the same episode of care for drugs that should have the same average sales price[6]. Community practices often purchase drugs at lower prices through group purchasing organizations (GPOs) and receive reimbursements based on average sales price (ASP) plus a margin. Hospitals also pay using ASP method and bundle lower cost drugs, but the higher markup is very significant. An example of this is the 340B Drug Pricing Program, which was implemented in 1992 to cover hospitals serving the poor but grew from $2.4 billion in 2005 to $12 billion in 2015[7]. The program was intended to provide discounted rates at 25% to 50% for hospitals serving low-income, underserved populations, without incentives.These discounted rates lowered drug costs to eligible hospitals. However, discounts did not involve the patient bill and therefor did not always equate to lower costs for patients or the intended indigent care needs. A study on the consequences of the 340B Drug Pricing Program found that hospitals could not be relied on to invest profits into care for the underserved without incentive[8]. An association with increased hospital-based use of parenteral drugs was also found[8]. Another study found that total drug spending per treatment episode rose by $4,075 in the first year after a hospital began 340B participation versus non-340B or commercially insured settings[9]. Hospitals eligible for the 340B discount charged a median of 3.08 times the purchase price and instituted markups as high as 6.59 times those of independent oncology practices. Non-340B hospital outpatient departments also charged more than physician offices, however only slightly higher than the median 340B hospitals at 4.34 times the purchase price. The 340B hospitals were found to retain 64.3% of the insurer-paid amount on infused cancer drugs as profit, compared to 44.8% at non-340B hospitals and only 19.1% in independent physician offices[10]. Hospitals using 340B discounts received $24.3 billion in sales at discounted prices in 2018[11]. The lower retained amount on infused cancer drugs in community oncology practices is a noteworthy difference which demonstrates the value of community oncology practices.

The Federal Hospital Price Transparency rule went into effect on January 1, 2021, requiring hospitals to publicly show payer-specific prices for drugs. A 2021 study of 61 National Cancer Institute (NCI) designated cancer centers looked at markup pricing and payer-specific prices per unit for cancer therapies. Findings included median drug price markups across all centers and payers ranging from 118.4% for immunotherapy, such as sipuleucel-T, to 633.6% for drugs like leuprolide. The study also found that 45% of hospitals were noncompliant with requirements to disclose payer-specific negotiated drug prices. Once disclosed, these drug prices typically exceeded Medicare payment limits[12]. In 2019, a Blue Cross Blue Shield analysis found infused cancer therapy to be 99% to 104% higher in hospital outpatient departments than physician offices and infused hormonal therapies, similar to leuprolide, to be 68% higher[13]. Furthermore, a matched-claims analysis of patients with breast, colorectal and lung cancers, using IMS LifeLink database, found that the cost per patient per month (PPPM) was significantly lower in a community ($10,507) versus hospital ($20,060) settings. Patients in this study were matched based on site of care, cancer type, chemotherapy regimen, receipt of radiation, surgical history, metastatic disease presence, gender and geographic region. The study observed significantly increased costs of care in the hospital setting due to increased cost of chemotherapy and provider visits in hospital-based clinics[14].This cost differential was irrespective of chemotherapy regimen and tumor type.

Another study from the Employee Benefit Research Institute (EBRI) found hospital prices for the top 37 infused cancer drugs averaged 86.2 percent more per unit than in physician offices. The mean annual reimbursement to providers per user of infused cancer drugs was $13,128 in physician offices compared to $21,881 in hospital out-patient departments (HOPDs). EBRI used data from the 2016 MarketScan Commercial Claims and Encounters database to estimate that commercial insurers would have saved $9,766 per treated member in 2016, if hospital unit prices matched physician office prices, a savings of 45 percent. They also found that on a drug-by-drug basis, HOPDs charged 1.3 to 4.3 times more than physician offices for oncology treatments[15].

Oncology treatments continue to expand as novel agents evolve and gain fast track approvals. The immuno-oncology (I-O) therapy class is an instance of treatment evolution demonstrating significant improvements in overall survival, clinical responses, efficacy, use for increasing indications as well as increasing costs. A retrospective analysis of Truven MarketScan and Supplemental Medicare claims databases utilized mean total PPPM and found I-O therapy cost was significantly lower for patients treated in a community ($22,685) versus hospital based ($26,343) settings[16].The I-O class of oncology treatments is estimated to reach $22 billion this year[17].The I-O analysis further demonstrates a class of cancer therapy associated with steep costs that can be decreased with use in the community versus hospital-based setting.

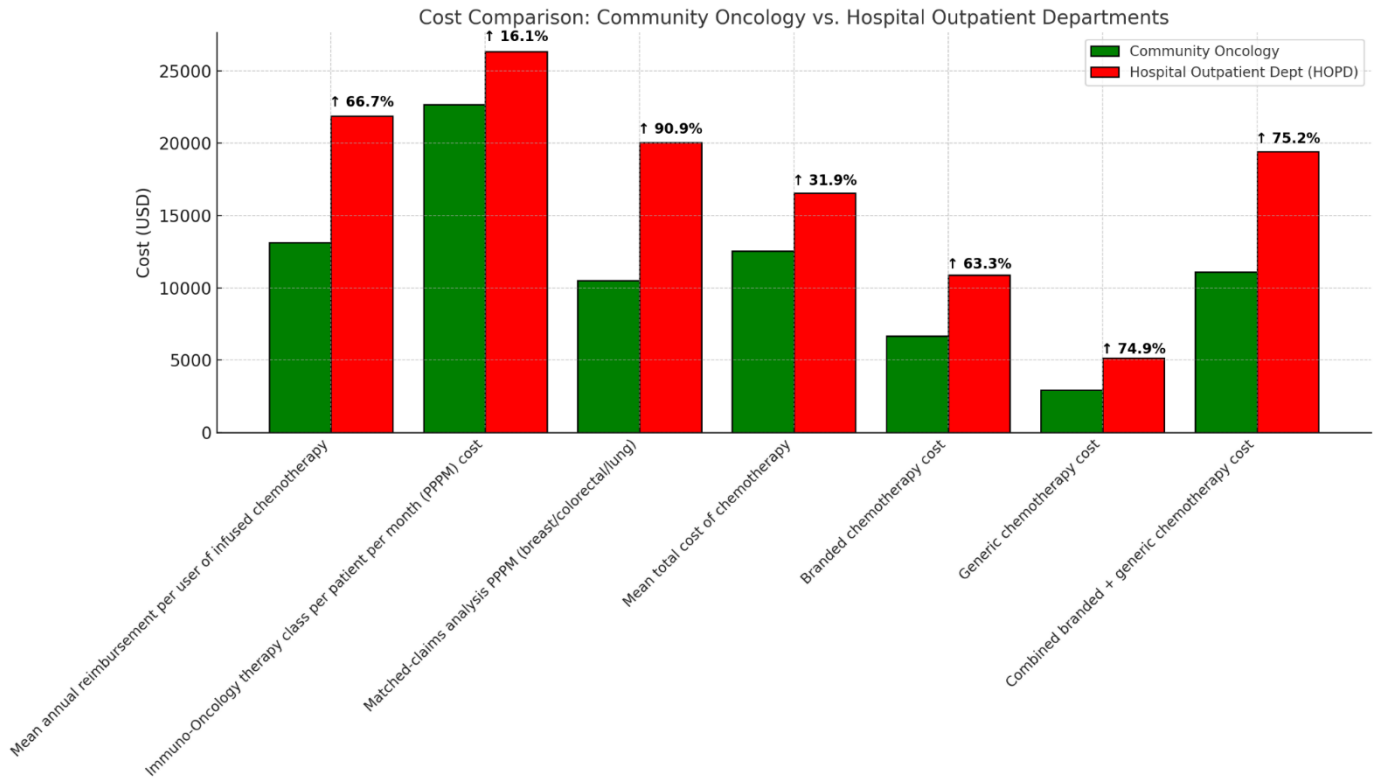
In addition to drug costs, there exists a substantial cost difference in the administration of chemotherapy in hospital-based oncology. Medicare chemotherapy spending by site of

care in 2019 found average spending per administration claim was almost twice as high in HOPDs compared with physician offices for most cancer types.[19] One example of this was spending per chemotherapy administration claim for colon cancer which was $182 in HOPDs compared with $100 in physician offices. Risk-adjusted chemotherapy administration spending was $322 higher in HOPDs than in physician offices[18]. The cost of cancer drugs and cost of administration have consistently been found to be higher in HOPDs than community oncology practices, as outlined in the table and graphic below.

Table 1.

Discussion	Community Oncology	HOPD	Year Published	Reference Title
Mean annual reimbursement per user of infused chemotherapy	$13,128	$21,881	2020	Location, location, location: Cost differences for oncology medicines based on site of treatment
Immuno-Oncology therapy class per patient per month (PPPM) cost	$22,685	$26,343	2019	Cost Differential of Immuno-Oncology Therapy Delivered at Community Versus Hospital Clinics
Matched-claims analysis of cost of treatment per patient per month (PPPM) in breast, colorectal and lung cancers	$10,507	$20,060	2018	Cost Differences Associated With Oncology Care Delivered in a Community Setting Versus a Hospital Setting: A Matched-Claims Analysis of Patients With Breast, Colorectal, and Lung Cancers.
Spending per chemotherapy administration Medicare claim for colon cancer	$100	$182	2018	Differences in Spending on Provider-Administered Chemotherapy by Site of Care in Medicare
Mean total cost of chemotherapy	$12,548	$16,555	2017	The Value of Community Oncology: Site of Care Cost Analysis.
Branded chemotherapy cost	$6,674	$10,900	2017	The Value of Community Oncology: Site of Care Cost Analysis
Generic chemotherapy cost	$2,936	$5,134	2017	The Value of Community Oncology: Site of Care Cost Analysis
Combined branded plus generic chemotherapy cost	$11,080	$19,412	2017	The Value of Community Oncology: Site of Care Cost Analysis

Figure 1.



Another driver of costs in hospital-based oncology practices are facility fees which can include funding for building infrastructures, equipment, IT infrastructure, housekeeping, security, around the clock nursing, pharmacy services, physician subsidies, support staff, and other overhead expenses. Community oncology clinics, on the other hand, do not separately bill facility fees and have lower administrative and operational expenses while hospital outpatient departments bill for a professional fee for physician services as well as a facility fee for hospital resources[19].These facility fees cause the total price for identical services in hospitals to be substantially higher for the patient & insurer. This can result in increased fees at hospital outpatient practices after acquisition for the same care, at the same location. A study on hospitals' ownership of clinical oncologists with Medicare payment data found that hospitals can generate $104,132 extra per oncologist per year for E&M services by integrating with oncologists[20]. In these situations, the physical location of oncology care has not changed, however additional fees can be incurred for the same prior services. The acquisition of community-based practices increased by 172% since 2008. This trend cannot be ignored as a contributing factor in the increasing cost of cancer care.[14]

In 2017, the Community Oncology Alliance (COA) Payer Exchange Summit found chemotherapy drug spending to be 71% higher per month in hospitals and monthly physician visit costs were three times greater in hospital settings. COA also noted 10 prior analyses from 2011 to 2016 that found hospital outpatient cancer care to be approximately 38% more expensive on average than community care.[4] An eleven-year Milliman study commissioned by COA, looked at claims data on Medicare and commercially insured patients from 2004 to 2014 and found that the estimated Medicare spending would have been $2 billion lower if the infused chemotherapy site of service shift had not occurred. They also noted cost increases for actively treated cancer patients were 36.4% more for Medicare patients and 62.5% more for commercially insured patients.

To reform the cost disparities in hospital-based practices, Congress mandated section 603 of the Bipartisan Budget Act (BBA) of 2015. Under this law, off-campus HOPDs would be paid by Medicare at non-facility rates, similar to freestanding offices, instead of the higher Hospital Outpatient Prospective Payment System (OPPS) rates[21]. This reform was intended to curb the growth of additional hospital-affiliated outpatient cancer centers where the same community site of care would increase in cost, after a hospital acquisition, due to the addition of facility rates. However, it allowed existing hospital clinics to continue to receive full OPPS payments. Healthcare policy makers have also debated the impact of site-neutral payment policies which encourage equal payment for the same services regardless of the location where the service is provided. In 2023, the American Cancer Society Cancer Action Network found that a breast cancer patient would have paid $1,500 less in out-of-pocket costs over one year if site-neutral pricing were applied[22]. Comparably, a 2024 study on site-neutral pricing for outpatient services in the employer-sponsored market found savings estimated around $847 billion, and nearly $900 billion when including individual health plans[23]. Moreover in 2023, the U.S. House passed the Lower Costs, More Transparency Act, which would expand site-neutral payments to drug administration services at off-campus hospital clinics, including exempt, grandfathered in facilities. Although this would end drug therapy cost disparities, the savings could lead to revenue losses for hospitals. The complexity of cancer care and the role of hospital-based practices in treating advanced cases should not be minimized by cost differences. Community oncology practices also face challenges that include delivering safe innovative care in the outpatient setting, especially when there is a need for increasing clinical trials outside of hospitals to ensure approved novel therapies can be safely administered in these settings.[24]

Community oncology practices are able to ease financial and logistical burdens through in-house specialty pharmacies and dispensaries to help patients access oral cancer drugs with minimal out-of-pocket costs. Community oncology practices may also provide grants, run charity drives, or work with foundations to assist eligible patients in need. An Avalere Health analysis found that hospitals receiving 340B discounts are not funneling savings into patient financial assistant or charity care and 29% of these hospitals spend less than 1% of total patient costs on charity care[25].This is a missed opportunity for hospitals to invest some profit into care for financially burdened patients.

In 2013, the National Academies of Science, Engineering, and Medicine (NASEM) described affordable health care as a key component to high-quality cancer care[26].The increasing cost of cancer care has led to the increased use of value-based models over fee-for-service models. Value-based frameworks (VBF) enable measurements of improvements in cancer health outcomes.A 2023 survey compared the use of different models in community and academic settings and found VBFs were used more often in community than academic settings[27]. Fee-for-service reimbursement encourages increased volume of services but does not take into consideration the quality or value of services provided. In 2024, the American Society of Clinical Oncology (ASCO), released a policy statement on Social Determinants of Health in Cancer Care, which highlighted financial toxicity as a barrier to fair outcomes.

DISCUSSION

Though there are no currently standardized measures to track and manage social needs such as financial toxicity, initiatives from both ASCO and the National Comprehensive Cancer Network (NCCN) are encouraging quality metrics that include the management of financial toxicity. Future reimbursement models for these types of services would include recognizing the value of financial navigation, social work, grant assistance, manufacturer assistance programs and financial assistance services[28].Community oncology practices provide both comparatively lower costs and patient-focused savings.

CONCLUSION

The resounding observation throughout this literature review is the consistently lower costs and comparable quality of care provided by community oncology practices relative to hospital-based settings. Anticancer treatments—particularly drug acquisition and administration—remain the principal drivers of overall cost differentials. Community oncology practices typically hold lower purchase prices, smaller mark-ups, and reduced retained margins on infused therapies. Facility fees and drug-administration charges likewise remain substantially lower in community settings. These findings highlight the urgent need for policy interventions aimed at reducing cost disparities that contribute to patient financial toxicity.

To translate these findings into meaningful reform, several actionable strategies warrant emphasis:

Implement Site-Neutral Payment Policies:Congress and regulatory agencies should adopt site-neutral reimbursement for oncology services—ensuring that identical services (e.g., chemotherapy administration, infusion care) are reimbursed at the same rate regardless of the care setting. Evidence from the Bipartisan Budget Act of 2015 and subsequent proposals (e.g., the Lower Costs, More Transparency Act of 2023) demonstrates that equalizing payments could yield billions in savings for payers and significantly reduce out-of-pocket burdens for patients without compromising quality of care.

Increase Price Transparency:Price opacity—particularly regarding drug mark-ups and facility fees—remains a major barrier to informed decision-making for both payers and patients. Strengthening compliance with the federal Hospital Price Transparency Rule (2021), mandating public disclosure of payer-specific negotiated prices for oncology drugs and administration fees, and enforcing penalties for non-compliance would empower patients, employers, and insurers to make value-based choices and further curb unjustified cost inflation.

Reform the 340B Program:Although the 340B Drug Pricing Program was established to support hospitals caring for underserved populations, evidence suggests that much of the accrued savings are retained as institutional margin rather than being redirected to patients in need. Mandating that a defined portion of 340B-related savings be allocated directly to patient financial-assistance programs and charity care would restore the program's original intent—relieving the economic burden for vulnerable patients—while maintaining institutional sustainability.

Support Community Oncology Infrastructure:Sustaining community oncology as a cost-effective care model requires dedicated investment in infrastructure for clinical trials, genomics-driven care, and innovative delivery models (e.g., in-office specialty pharmacies, tele-oncology, financial-navigation services). Policymakers and payers should provide incentives, grants, or enhanced reimbursement pathways to ensure that community sites remain equipped to deliver advanced therapies safely and equitably outside of tertiary hospital centers.

Advance Consumer Education: Financial toxicity is exacerbated by limited public understanding of cost differences between sites of care. National cancer advocacy groups, payers, and health-system stakeholders should collaborate on consumer-facing educational initiatives to inform patients about the comparative costs, quality metrics, and available financial-assistance resources in different oncology settings. Educated patients and caregivers are more empowered to select cost-effective care options, potentially lowering their own financial exposure.

In summary, community oncology practices—by virtue of their lower drug acquisition costs, reduced administrative overhead, and patient-centered support services—play a pivotal role in mitigating cancer-related financial toxicity. Legislative efforts that promote site-neutral payment, enforce price transparency, reform the 340B program to prioritize patient benefit, invest in community infrastructure, and enhance consumer education collectively offer a pragmatic framework for curbing avoidable cost escalation in U.S. cancer care. Aligning these policy strategies with ongoing ASCO and NCCN initiatives on financial toxicity will be essential to advancing equitable, high-value oncology care nationwide.

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